

CHRISTIE MEDICAL CLINIC
2661 RIVA ROAD, SUITE 610
ANNAPOLIS, MD 21401

PERSONAL

MALE FEMALE Today's Date _____

Patient Name _____ Birth Date _____

Street Address _____

City _____ State _____ Zip Code _____

Marital Status: Single Married Divorced Widowed Separated

Social Security Number _____ - _____ - _____ Home Phone (_____) _____ - _____

Work Phone (_____) _____ - _____ Cell Phone (_____) _____ - _____

Are you allergic to any medications? Yes No If yes, what medications? _____

How did you hear about us? Drive-By Internet Search Our Website Other _____

EMPLOYMENT Are you employed? Yes No

Current Employer _____

Address _____ Phone (_____) _____ - _____

INSURANCE

HMO PPO OTHER SELF PAY WORKER'S COMP

Primary Insurance

Secondary Insurance

Insurance Name _____

Address & Phone _____

Policy/ID Number _____

Group Number _____

Relationship to Holder _____

HIPPA

I am here for treatment, payment and health care services for myself, my child/children. I can refer to the practice's Notice of Privacy Practice for specific information regarding this practice's used of protected health care information.

Signature of Patient/Guardian

Date

Print Name

**CHRISTIE MEDICAL CLINIC
ANNAPOLIS, MD**

PATIENT AUTHORIZATION

I, _____, hereby authorize Dr. John E. Christie of Christie Medical
(PRINT NAME)

Clinic, Inc. to apply for benefits on my behalf for services rendered by Christie Medical Clinic, and request that payments from my insurance company be made directly to Christie Medical Clinic.

I certify that the information I have reported with regard to my insurance coverage is correct, and further authorize the release of any necessary information including medical information, to my insurance company or companies (or in the case of Medicare Part B benefits, to the Social Security Administration and Health Care Financing Administration).

I permit a copy of this authorization to be used in place of the original. I also hereby assign my major medical benefits payable in relationship to services rendered by Christie Medical Clinic. I (We) understand that I (we) am totally responsible for payment of my account, unless Christie Medical Clinic has previously arranged by contractual agreement to accept payment in full for services (less copays, deductibles, co-insurance and/or non-covered services).

I (We) understand a late charge of \$5.00 is assessed monthly to my account balances for any balance over 60 days old. I (We) accept financial responsibility for all charges billed, and the undersigned (jointly and severally) guarantee to pay all such charges. **All bills are payable and become due on presentation.** I (We) agree if payment of bills rendered is not made, and collection efforts are required, I (we) hereby agree to pay all bills rendered to me (us) together with all collection costs, interest fees, and reasonable attorney's fees of 35% of the balance due.

The undersigned certifies that he/she has read and understands the foregoing and is the patient, or is duly authorized by the patient as the patient's general agent to execute the above and accepts its terms.

Witness my hand and seal this _____ day of _____, 20____.
Day Month Year

**** PATIENT SIGNATURE**

**** WITNESS SIGNATURE**

PRINTED PATIENT NAME

PRINTED WITNESS NAME

**** OTHER RESPONSIBLE PARTY SIGNATURE**

**** SOCIAL SECURITY # OF RESPONSIBLE PARTY**

PRINTED NAME OF OTHER RESPONSIBLE PARTY

RELATIONSHIP TO PATIENT

ADDRESS OF OTHER RESPONSIBLE PARTY

CITY, STATE, ZIP CODE

**** HOME PHONE NUMBER OF RESPONSIBLE PARTY**

**** WORK NUMBER OF RESPONSIBLE PARTY**